



State Corporation Commission
Bureau of Insurance
Life and Health Division
Office of the Managed Care Ombudsman
Post Office Box 1157
Richmond, VA 23218

**Internet
Version**

Inquiry Form
Managed Care Health Insurance Plan (MCHIP)

Complete this form if you want help with an appeal.

Name: _____
Birthdate _____ Sex _____
Address _____
City _____ State _____ ZIP Code _____
Work Phone Number (____) _____ Home Phone Number (____) _____

If this appeal is not for you, please tell us who is and explain your relationship:

Are you covered by Medicare _____? Medicaid _____?

MCHIP Name _____
Address _____
City _____ State _____ ZIP Code _____

MCHIP Enrollee Policy Certificate or ID Number _____

Type of MCHIP

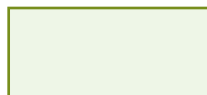
_____ HMO (Health Maintenance Organization) _____ PPO (Preferred Provider Organization)
_____ POS (Point of Service) _____ Other _____

Source of Coverage Group _____ Individual _____

If group coverage, name and address of employer:

Nature of Appeal – **Check all box(es) that apply:**

- | | |
|--|--|
| <input type="checkbox"/> Claim | <input type="checkbox"/> Denial of Treatment |
| <input type="checkbox"/> Underwriting | <input type="checkbox"/> Availability of Provider/Facility |
| <input type="checkbox"/> Administrative | <input type="checkbox"/> Out-of-Network Care |
| <input type="checkbox"/> Surgical Procedure | <input type="checkbox"/> MCHIP Policy/Procedure |
| <input type="checkbox"/> Emergency Room Services | <input type="checkbox"/> Dental/Oral Surgery |
| <input type="checkbox"/> Prescription Medication | <input type="checkbox"/> Other _____ |



**For Office Use
Only**

Briefly describe the circumstances regarding your appeal.

Please give a brief summary of the MCHIP's response to any appeal you have made.

Date	Phone/Letter	MCHIP Staff Name and Title	MCHIP Response
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Please name other parties you have contacted. (Example: other state agencies, an attorney, etc.)

I am enclosing copies of correspondence or other documents (correspondence from providers, and correspondence to or from the MCHIP) relating to this matter that may help the Bureau of Insurance (BOI) in its evaluation of my inquiry. I understand and agree that a copy of this form and any information I provide may be forwarded to the MCHIP or one of its contracted providers in order for the BOI to assist me. I also agree that by signing this form, I authorize the BOI to obtain any additional information, including copies of my medical records, required to assist me.

Signature

Date

Signature of Insured/Enrollee (if different from above)

Disposition

☐
☐

Referred to CSS

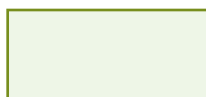
Referred to VDH

☐
☐
☐

Resolved

Referred to External Review

Referred to _____



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